Walter Reed Cardiovascular Center

A Monthly Newsletter of the Cardiology Division of Walter Reed Army Medical Center

Commentary
Thomas Wiley, MD FACC

The electronic consult for new patient appointments is in evolution. Presently, it is a reliable method to obtain a Cardiology Consult. It also ensures that contact information is available so that we are able to provide immediate feedback to you.

Unfortunately, this method cannot be reliably used to obtain stress tests, Holters or ECHOs. When appointing the electronic consults, the Tricare Service Center does not screen the requests for these tests. All requests are appointed in a new patient slot. Until this system wide problem is solved, these requests still require written consults (or a CHCS Radiology order for an ECHO). The patient can schedule directly by calling 202-782-3832/3833.

Cardiovascular Update
Daniel E. Simpson, MD FACC

Atrial fibrillation is the most common sustained arrhythmia encounter in clinical practice. Its prevalence increases with age. The optimal treatment strategy, especially in older asymptomatic patients, has been debated. Many have taken an aggressive approach at maintaining sinus rhythm rather than rate control with anti-coagulation.
Two recent trial outcomes have supported the conservative approach of rate control and anti-coagulation instead of maintaining sinus rhythm. The largest trial, AFFIRM, is described below.

AFFIRM*
4060 patients with a mean age of 69.7 were randomized to cardioversion & anti-arrhythmic drugs versus rate control. Anti-coagulation was recommended in the rhythm control group and mandated in the rate control group.

The 5-year mortality was equivalent (23.8% v 21.3 % P = 0.08). There were more hospitalizations and adverse drug effects in the rhythm control group. As a result, an editorialist states "rate control can now be considered a primary approach to the treatment of atrial fibrillation".

* NEJM 2002;347:1825-33
www.nejm.org

Guideline Review
Daniel E. Simpson, MD FACC

Class I – General agreement that procedure/treatment is useful & effective
Class II – Conflicting evidence and/or divergence of opinion (a & b)
Class III – Not useful/effective and in some cases may be harmful
Ambulatory ECG (AECG)*
An AECG is widely used to determine the relation of a patient's symptoms to an arrhythmia. Common symptoms associated with arrhythmias are syncope, near syncope, lightheadedness and palpitation not SOB, CP, weakness, diaphoresis, neurological symptoms or vertigo. The specific recording technique – 24-48 hour Holter, intermittent event recorder, or implantable loop recorder – depends upon the duration and frequency of symptoms.

Class I
- Patients with unexplained syncope, near syncope, or episodic dizziness (lightheadedness) in whom the cause is not obvious
- Patients with unexplained recurrent palpitation

Class IIb
- Patients with episodic shortness of breath, chest pain, or fatigue that is not otherwise explained
- Patients with neurological events when transient atrial fibrillation or flutter is suspected
-Patients with symptoms such as syncope, near syncope, episodic dizziness, or palpitation in whom a probable cause other than an arrhythmia has been identified but in whom symptoms persist despite treatment of this other cause

Class III
-Patients with symptoms such as syncope, near syncope, episodic dizziness, or palpitation in whom other causes have been identified by history, physical examination, or laboratory tests
- Patients with cerebrovascular accidents, without other evidence of arrhythmia

*ACC/AHA – Guidelines for Ambulatory ECG
www.acc.org/clinical/statements.htm

Cardiovascular Trials at WRAMC

ARBITER II
Comparison of niacin versus placebo in patients with CAD with an LDL < 130 on a statin and HDL < 45.

Questions/Referrals
Please contact Lance Sullenberger or Allen Taylor

CARDIASTAR
PFO closure device versus standard anti-coagulation therapy with coumadin in patients with an embolic TIA/CVA and no other etiology.

Questions/Referrals
Please contact Timothy Lee or Daniel Simpson

TRIACTIVE
Distal embolic protection device during percutaneous coronary intervention in SVGs.

Questions/Referrals
Please contact Daniel Isenbarger or Daniel Simpson